Docket No. 03-55601

IN THE UNITED STATES COURT OF APPEAL
FOR THE NINTH CIRCUIT

KARLA H. ABATIE, an individual

Plaintiff-Appellant

vs.

ALTA HEALTH & LIFE INSURANCE COMPANY,
a Delaware corporation, etc.

Defendant-Appellee

On Appeal From an Order and Judgment of the
United States District Court for the Central District of California

PETITION FOR REHEARING EN BANC

AND FOR PANEL REHEARING

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I. INTRODUCTION AND STATEMENT OF COUNSEL

Karla Abatie, appellant in Abatie v. Alta Health & Life Insurance Company (No. 03-55601), seeks rehearing *en banc* of the August 31, 2005, Panel decision (Beezer, J. and Tallman, J., with Pregerson, J. dissenting) concerning two issues of national significance under the Employment Retirement Income Security Act of 1974, 29 U.S.C. § 1001, et seq. ("ERISA.") Among other things, the Panel majority held that (1) an ERISA plan administrator may assert a new reason for denying a claim after the instigation of litigation, when that reason was known to the administrator before litigation commenced but never communicated to the beneficiary (referred to in Judge Pregerson's dissent as "sandbagging"); and (2) an ERISA plan administrator has discretion not to consider relevant deposition testimony submitted by the plan beneficiary in support of her claim and which is part of the administrative record (referred to by the dissent as "cherry-picking.")

Abatie seeks rehearing *en banc* of the issues identified above. In the judgment of counsel, rehearing *en banc* is necessary because the Panel's opinion overlooks established ERISA law and directly conflicts with decisions of this Court and other Circuit Courts on issues of exceptional importance. (Fed. R. App. P. 35.) These issues are important since the "purpose of ERISA is to provide a *uniform* regulatory regime over employee benefit plans." Aetna

Health Inc. v. Davila, 542 U.S. 200, 124 S. Ct. 2488, 2495 (2004; emphasis added.) *See also*, Zipf v. American Tel. & Tel Co., 799 F.2d 889, 892 (3d Cir. 1986), noting that one purpose of the ERISA laws is to encourage "the consistent treatment of claims for benefits...," and Secretary of Labor v. Fitzsimmons, 805 F.2d 682, 690 (7th Cir. 1986), holding that ERISA "plans affect[] the national public interest in employment stability and industrial relations...." Because of the established goal of promoting uniformity in the application of ERISA, *en banc* review is appropriate to ensure that the Panel opinion conforms to both the law of this Circuit as well as others.

In the alternative, Abatie requests a panel rehearing on the grounds that the Panel opinion conflicts with existing Ninth Circuit and statutory authority. (Fed. R. App. P. 40.) For the reasons set forth below, the Court should grant the instant petition.

II. PETITION FOR REHEARING EN BANC

A. The Panel Incorrectly Held that Alta Was Entitled to Assert a New Basis for Denying Abatie's Claim after Abatie had Commenced Litigation to Enforce Her Rights under the Plan

This action arises from the denial of life insurance benefits under an ERISA-governed plan both funded and administered by appellee, Alta Health & Life Insurance Company. During the course of considering Abatie's claim, Alta offered two different reasons for denying the claim. When Abatie initially

submitted her claim, Alta denied the claim on the sole ground that Abatie's decedent, Dr. Joseph Abatie, had not submitted a request for a waiver of premium within 12 months of his total disability, under the terms of the plan. (Excerpts, Vol. II, pp. 287-288.) Later, after Abatie filed suit and Alta agreed to conduct a further administrative review, Alta again denied the claim. In the second denial, however, in addition to citing the 12-month waiver of premium requirement, Alta for the first time asserted that it did not owe benefits because insufficient evidence existed that Dr. Abatie had been continuously disabled. (Excerpts, Vol. I, pp. 211-222.)

The Panel held that Alta's belated reliance on Dr. Abatie's alleged lack of disability as a basis for denying the claim was not probative evidence of any actual conflict of interest because Alta's second rationale was merely an "additional" reason for denying benefits as opposed to an "inconsistent" reason. (Slip op. at 11830.) More specifically, the Panel concluded:

> We hold that an ERISA administrator's articulation of a new reason for denying a claim on appeal after the initial benefit determination has been rendered is permissible and so does not constitute material, probative evidence that the administrator's conflict of interest manifested itself into an actual breach of its fiduciary obligations. (Slip op. at 11832.)

As set forth below, this holding expressly conflicts with cases from other jurisdictions as well as from the Ninth Circuit.

A nearly identical situation was addressed by the First Circuit in Glista v.

Unum Life Insurance Company of America, 378 F.3d 113 (1st Cir. 2004). There, an ERISA plan administrator denied benefits based upon language in the plan which excluded coverage for pre-existing conditions. The pre-existing condition provision contained two independent parts:

> You have a pre-existing condition if:
> you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage [the Treatment Clause]; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 3 months just prior to your effective date of coverage [the Symptoms Clause]. (*Id.* at 116.)

When presented with the beneficiary's claim, Unum initially denied coverage based solely on the Treatment Clause of the plan. After the beneficiary filed suit to recover policy benefits, Unum contended for the first time that the Symptoms Clause also supported its denial of coverage. (*Id.* at 119-120.)

The court concluded that Unum's reliance on a new basis for denying coverage was improper:

> Having determined that the denial of benefits cannot be justified under the Treatment Clause, we turn to Unum's reliance on the Symptoms Clause. Glista argues, inter alia, that Unum should not be permitted to rely on the Symptoms Clause in litigation because it did not rely on that clause in its communications to him during the internal review process. We agree. (*Id.* at 128.)

The basis for the court's holding was that Unum could have asserted the Symptoms Clause as a reason for denial, based on the information it had at the time of the initial coverage decision, but chose not to do so. After discussing

the ways in which the ERISA statutes and Department of Labor regulations express the goal of ensuring meaningful communication and cooperation between beneficiaries and plan administrators, the court held:

> Those goals are undermined *where plan administrators have available sufficient information to assert a basis for denial of benefits, but choose to hold that basis in reserve rather than communicate it to the beneficiary*. Such conduct prevents ERISA plan administrators and beneficiaries from having a full and meaningful dialogue regarding the denial of benefits. (*Id.* at 128-129; emphasis added.)

The court decided to "hold Unum to the basis that it articulated in its internal claims review process for denying benefits, i.e., the Treatment Clause," reversing the judgment in favor of Unum and directing that judgment be entered in favor of the ERISA beneficiary." (*Id.* at 132.)

The instant case mirrors the facts in Glista since Alta was aware of the facts allegedly supporting the second ground for denial when it issued the first denial based solely on the 12-month submittal requirement. Prior to the initial denial, Alta was in possession of a report from its physician which asserted that, although Dr. Abatie had been continuously disabled from any occupation from 1992 to 1998, insufficient evidence existed to establish that Dr. Abatie was unable to perform sedentary work for a period of one and a half years shortly before his death. (Excerpts, Vol. II, pp. 287-288, 290, 292, 374.) As in Glista, Alta could have asserted the supposed lack of evidence of Dr. Abatie's disability when it initially denied Abatie's claim, but it opted not to do so.

Therefore, under Glista, Alta violated the important principles of the ERISA scheme in ensuring a "full and fair" review of Abatie's claim by not initially providing her with all known bases for denying her claim. 29 U.S.C. § 1133; 29 C.F.R. 2560.503-1 (1999).

This conclusion is supported by decisions from other circuits as well as the Ninth Circuit, which have described the practice utilized by Alta as "sandbagging." For example, the Eighth Circuit, in Marolt v. Alliant Techsystems, Inc., 146 F.3d 617 (8th Cir. 1998), held: "We will not permit ERISA claimants denied the timely and specific explanation to which the law entitles them to be sandbagged by after-the-fact plan interpretations devised for purposes of litigation." (*Id.* at 620.) *See also*, Abram v. Cargill, 395 F.3d 882, 886 (8th Cir. 2005), citing Marolt and holding that an ERISA plan administrator violated the law by failing to provide the beneficiary with information "that served as the basis for the Plan's denial of benefits until after the Plan's decision."

Similarly, in an opinion from the Seventh Circuit, the court rejected a "post hoc attempt to furnish a rationale for a denial of pension benefits...." Halpin v. W.W. Grainger, Inc., 962 F.2d 685, 696 (7th Cir. 1992), quoting Short v. Central States, S.E. & S.W. Areas Pension Fund, 729 F.2d 567, 575 (8th Cir. 1984.)

The Ninth Circuit's opinion in Jebian v. Hewlett-Packard Company Employee Benefits Organization Income Protection Plan, 349 F.3d 1098 (9th Cir. 2003) also prohibits the practice of sandbagging ERISA claimants. In Jebian, the plan administrator failed to respond to a claim within the time prescribed by law, thus making the claim "deemed denied" under the applicable Federal Regulations. The court rejected a subsequent attempt by the administrator to offer a substantive rationale for denying the claim:

> [A] contrary rule would allow claimants, who are entitled to sue once a claim had been "deemed denied," to be "sandbagged" by a rationale the plan administrator adduces only after the suit has commenced. Our refusal to subject claimants to that eventuality parallels the general rule that an agency's order must be upheld, if at all, on the same basis articulated in the order by the agency itself, not a subsequent rationale articulated by counsel. (*Id.* at 1104; internal quotations and citations omitted.)

Accordingly, in Jebian, which the Panel opinion did not address, the court held that a plan administrator may not deny an ERISA claim for reasons provided to the beneficiary only after the commencement of litigation. Notably, the Jebian court did not limit its holding only to situations where the post-litigation reason for denial is inconsistent with prior rationales. Indeed, contrary to the Panel majority's opinion, no authority requires that a supplemental reason asserted for denying a claim after litigation has commenced must also be inconsistent with the previously adduced rationale in order to give rise to a conflict of interest. While some Ninth Circuit opinions have rightfully held that inconsistent

reasons for denying benefits do constitute evidence of a conflict of interest entitling the beneficiary to *de novo* review, these cases have not held that such inconsistency is *required* in order for a finding of conflict of interest.

For example, in Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., 125 F.3d 794 (9th Cir. 1997), relied upon by the Panel majority, the court held: "We conclude that the inconsistencies in the reasons Standard gave for its refusals to lift the 'mental disorder' limitation constitute material, probative evidence that its decision was affected by self interest." (*Id.* at 799.) The court in Lang, however, did not suggest that differing rationales for denying a claim *must* be inconsistent in order for a conflict of interest to exist.

Similarly, in Nord v. Black & Decker Disability Plan, 356 F.3d 1008 (9th Cir. 2004), the court held only that evidence of a conflict of interest "*may* consist of inconsistencies in the plan administrator's reasons, insufficiency of those reasons, or procedural irregularities in the processing of the beneficiaries claims." (*Id.* at 1010; italics added.) Accordingly, contrary to the Panel majority's position, inconsistency is not necessary for a subsequently adduced rationale for denying a claim to be considered probative evidence of a conflict of interest on the part of an ERISA plan administrator. Rather, the fact that a supplemental rationale is provided by the administrator after litigation has commenced is sufficient, by itself, to give rise to a conflict entitling the

beneficiary to *de novo* review. Glista, Jebian, *supra.*

The authorities cited above strive to uphold the basic maxim that there be "a meaningful dialogue between ERISA administrators and their beneficiaries. If benefits are denied in whole or in part, the reason for the denial must be stated in reasonably clear language, with specific reference to the plan provisions that form the basis for the denial...." Booton v. Lockheed Medical Benefit Plan, 110 F.3d 1461, 1463 (9th Cir. 1997.) In the case at bar, Alta failed to facilitate a meaningful dialogue by not advising Abatie of the "lack of evidence of disability" basis for denying her claim despite possessing the evidence upon which Alta relied to support its position, which prevented Abatie from presenting further evidence to rebut Alta's position.

The Panel's decision approving Alta's conduct is inconsistent with the First Circuit's holding in Glista, *supra*, as well opinions from the Eighth, Seventh, and Ninth Circuit which have expressly disallowed the practice of "sandbagging" and "post-hoc" rationalization. Marolt, Abrams, and Jebian, *supra.* Thus, to ensure nationwide uniformity in how ERISA plans are interpreted and applied to claimants, the court should grant *en banc* review in the present case.

B. The Panel Opinion Impermissibly Permits the Plan Administrator to "Cherry-pick" Evidence Submitted by the Claimant

Among the evidence submitted by Abatie to Alta during Alta's review

was the deposition testimony of Melissa Peter, an individual formerly employed by Abatie's husband's employer, Santa Barbara Medical Foundation Clinic, who testified that she personally requested and obtained a waiver of premium from Alta's predecessor on behalf of Dr. Abatie. This testimony augmented the written documentary evidence supporting Abatie's claim that a waiver of premium had been timely requested of Alta's predecessor-in-interest and that Alta had approved the waiver. Alta's letter denying benefits, however, wholly failed to mention the deposition testimony that was favorable to Abatie.

The Panel majority concluded that no such discussion was necessary since Alta was entitled to make its decision solely on the written documentation in the administrative record. Namely, the Panel held:

> We conclude that Alta was under no obligation to discuss deposition testimony about the alleged waiver of premium application....In assessing whether the waiver of premium application and accompanying proof of disability was ever filed, we hold that a plan administrator is entitled to rely exclusively on the written documentation in the administrative record, a record to which both sides had the opportunity to contribute. (Slip op. at 11834.)

Thus, the Panel concluded that Alta had no obligation to consider the deposition testimony submitted by Abatie, even though Alta participated in the deposition and the transcript of that testimony became part of the administrative record.

The Panel further limited Alta's obligations by holding that Alta did not have to consider any evidence that was "non-dispositive." The Panel opinion

states:

> We further hold that a mere failure of an administrator to discuss evidence does not violate ERISA principles where the evidence is non-dispositive in the first instance.... We need not linger over the application of these principles to the case at hand. There was good reason for the administrator not to discuss the deposition testimony, because the Peter deposition would not have affected the outcome, and it was both ambiguous and unreliable. The deposition testimony is non-dispositive for these three independent reasons, removing it from any possible class of evidence that an administrator *must* discuss. (Slip op. at 11836-11837; italics in original.)

As set forth below, the Panel's holdings are contrary to established precedent and therefore an *en banc* rehearing is warranted.

The ERISA statute outlining the claims procedure provides for a "*full* and fair" review procedure. (29 U.S.C. § 1133; italics added. Slip op. at 11847-11848, Pregerson, J. dissenting.) In order to adhere to this requirement, an ERISA plan administrator must consider all evidence before it. In Grossmuller v. International Union, UAW, Local 813, 715 F.2d 853 (3d Cir. 1983), the court held: "To afford a plan participant whose claim has been denied a reasonable opportunity for full and fair review, the plan's fiduciary must consider any and all pertinent information reasonably available to him." (Id. at 857.) Current ERISA regulations are consistent with this rule, mandating that an administrator: "Provide for a review that takes into account *all* comments, documents, records, and other information submitted by the claimant relating to the claim...." (29 C.F.R. § 2560.503-1(h)(2)(iv); italics added.)

The Panel opinion carves out two unwarranted exceptions to the rule that a plan administrator must take into account "all" information provided by the beneficiary: one for deposition testimony and one for so-called "non-dispositive" evidence. However, contrary to the Panel's opinion, the ERISA statutes and regulations do not contain any provisions so limiting the administrator's responsibility. Rather, *all* evidence is to be considered as part of a *full* review. Accordingly, because the Panel's decision conflicts with statutory, regulatory, and common law authority, *en banc* review is appropriate.

The Panel majority's holding regarding the deposition testimony is based in great part upon its characterization of the testimony as "self-serving," "ambiguous," and "unreliable." (Slip op. at 11836-11837.) This credibility determination, however, is entirely unsupported by the record. Alta never raised any issue regarding the reliability of the deposition testimony in denying Abatie's claim. (Excerpts, Vol. I., at 211-222.) Indeed, as stated previously, Alta did not consider the testimony at all. (*Id.*)

Likewise, the District Court made no finding whatsoever that the deposition testimony was not credible. (Excerpts at 145-163.) Since one must assume, therefore, that the District Court did not find the deposition testimony to lack credibility, the Panel should have given that finding deference. EEOC v. Bruno's Restaurant, 13 F.3d 285, 287 (9th Cir. 1992); Connors v. Conn. Gen.

Life Ins. Co., 272 F.3d 127, 135 (2d Cir. 2001); Hopkins v. Seagate, 30 F.3d 104, 106 (10th Cir. 1994.) Because the Panel's novel findings with respect to the credibility of the Peter deposition are contrary to these authorities, an *en banc* rehearing is justified.

III. PETITION FOR PANEL REHEARING IN THE ALTERNATIVE

In the alternative to a rehearing *en banc*, Abatie requests a panel rehearing. (Fed. R. App. P. 40.) As discussed in Part II, above, the Panel opinion held: (1) that Alta was permitted to introduce a rationale for denying Abatie's claim that was not included in its initial denial of benefits and was not introduced until after Abatie commenced litigation; and (2) that Alta could lawfully decline to take deposition testimony submitted by Abatie into consideration in reaching its coverage decision. For the reasons previously enumerated, these conclusions were in error since they conflict with existing Ninth Circuit and statutory law. Therefore, if a rehearing *en banc* is denied, Abatie requests a panel rehearing in order to decide these issues and to determine her claim that Alta wrongfully denied her benefits under ERISA.

IV. CONCLUSION

Abatie respectfully submits that the Panel decision incorporates holdings that conflict with decisions from other Circuits on issues of national importance and that conflict with prior statutory and Ninth Circuit authority. Therefore,

Abatie requests *en banc* rehearing of the issues identified herein, or panel rehearing as appropriate, for the reasons set out in the statement of counsel, above.

Dated: September 13, 2005

Respectfully submitted,

GRIFFITH & THORNBURGH, LLP

By: _____
Craig Price
Attorneys for Appellant, Karla H. Abatie

CERTIFICATE OF COMPLIANCE PURSUANT TO FED. R. APP. P. 32(a)(7)(C) AND CIRCUIT RULE 32-1 FOR CASE NUMBER 03-55601

I certify that:

1. Pursuant to Fed. R. App. P. 32(a)(7)(c) and Ninth Circuit Rule 32-1, the attached Petition for Rehearing and Rehearing En Banc is proportionately spaced, has a typeface of 14 points or more, and contains 3,202 words.

Dated: September 13, 2005

GRIFFITH & THORNBURGH, LLP

By: _____
Craig Price
Attorneys for Appellant, Karla H. Abatie

Case No. 03-55601

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

KARLA H. ABATIE
plaintiff-appellant

v.

ALTA HEALTH & LIFE INSURANCE COMPANY
defendant-appellee

ANSWER TO PETITION FOR REHEARING

Appeal from the United States District Court
for the Central District of California,
the Honorable John F. Walter,
United States District Judge

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INTRODUCTION

This is an action to recover life insurance benefits under an ERISA-governed employee welfare benefit plan. Alta, the claims administrator, denied Plaintiff's claim for two reasons: (1) the evidence in the administrative record established that no waiver of premium application had been submitted within 12 months after the onset of Dr. Abatie's disability; and (2) the evidence in the administrative record established that Dr. Abatie did not remain totally and continuously disabled until his death. Applying an abuse of discretion standard of review, the district court affirmed Alta's decision, and this court affirmed the district court.

Plaintiff's petition for rehearing raises two arguments. First, Plaintiff argues that during litigation Alta improperly relied on a basis for denying Plaintiff's claim that Alta did not express during the administrative review process. That argument is factually inaccurate. Because Plaintiff prematurely commenced litigation before exhausting her remedies under the plan, this lawsuit was filed before the administrative review process was finished. But the parties agreed to finish the administrative review process before adjudicating those claims. Only after the administrative review process was completed did Plaintiff and Alta present their respective positions to the district court for decision. And the arguments that Alta presented to the district court were identical to the reasons for denying the claim

that Alta articulated in the administrative review process. Therefore, Alta did not assert in litigation any reasons for denying Plaintiff's claim that were not articulated in the administrative review process.

Plaintiff's second argument is her contention that the panel held that Alta was not required to consider certain deposition testimony that Plaintiff obtained in discovery and submitted for Alta's consideration during the administrative review process. The problem with this argument is that the court did not hold that Alta did not have to consider the deposition testimony submitted by Plaintiff. In fact, that issue wasn't even presented to the court because the court held that Alta *had* considered the testimony. Since Alta *did* consider the testimony, the court had no reason to decide whether Alta was justified in ignoring the testimony.

The court also held that Alta was not required to *discuss* the deposition testimony in its final decision concerning Plaintiff's claim. But holding that Alta was not required to *discuss* the deposition testimony in its written decision is not the same as holding that Alta was not required to *consider* the testimony. The fact that Alta did not discuss the testimony does not mean that Alta did not consider it.

Finally, even if the court *had* held that Alta was not required to consider the deposition testimony, any such holding would have been dicta because, as the court held, Alta *did* consider the testimony. For all of these reasons, the petition for rehearing should be denied.

STATEMENT OF CASE

A. The panel affirmed the district court, which had upheld Alta's denial of Plaintiff's claim for life insurance benefits.

Alta denied Plaintiff's claim for life insurance benefits. Applying an abuse of discretion standard of review, the district court upheld that decision.

By a 2-1 vote, the panel affirmed the district court.[1] The panel held: (1) Alta's decision was subject to an abuse of discretion standard of review because the plan conferred discretion on the claims administrator; (2) a less deferential standard of review was not warranted because Plaintiff failed to present material, probative evidence that Alta's decision was affected by a conflict of interest; and (3) Alta's decision was supported by evidence in the administrative record.

B. Plaintiff petitioned for rehearing of the court's holding that Plaintiff did not present material, probative evidence of a conflict of interest.

Plaintiff has petitioned for rehearing. The petition asks this court to change its decision by holding that a de novo standard of review applies because Plaintiff presented material, probative evidence that Alta's decision was affected by a conflict of interest. The petition for rehearing should be denied.

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[1] The decision is published at 421 F.3d 1053 (9th Cir. 2005).

ARGUMENT

A. Contrary to Plaintiff's argument, Alta did not, in litigation, rely on any reason for denying Plaintiff's claim that was not articulated during the administrative review process; and even if Alta had done so, it would not justify applying a de novo standard of review.

1. Alta did not, in litigation, rely on any grounds for denying Plaintiff's claim that was not set forth during the administrative review process.

Plaintiff's first argument involves Alta's stated reasons for denying Plaintiff's claim. After Dr. Abatie's death, Plaintiff applied for life insurance benefits. At the first level of review, Alta denied Plaintiff's claim for a single reason: there was no evidence that anyone applied for a waiver of premium within 12 months after Dr. Abatie became disabled.

Plaintiff then filed this lawsuit. And, according to the version of events recited in Plaintiff's petition for rehearing, during the course of litigation Alta improperly raised an additional grounds for denying Plaintiff's claim that was not articulated during the administrative review process: there was insufficient evidence that Dr. Abatie remained totally and continuously disabled from 1992 until his death.

Plaintiff argues that by raising this second, additional grounds for denying Plaintiff's claim only after litigation had begun, Alta acted improperly, and that

improper conduct was material, probative evidence of a conflict of interest, warranting application of a de novo standard of review.[2]

This argument has several flaws, but the starting point is this: the argument is based on the false premise that Alta asserted in litigation a reason for denial that was never presented during the administrative review process. But Plaintiff's characterization of the facts is a gross distortion of what really happened.

The chronology of events is undisputed. Dr. Abatie died in June 2000. In December 2000, the clinic sent a letter to Alta seeking life insurance benefits.[3] In March 2001, Alta denied the claim on the grounds that Dr. Abatie had never applied for the waiver of premium benefit.[4]

Alta's letter explained how to appeal the decision.[5] And Plaintiff was required to exhaust her remedies under the plan before commencing litigation.[6]

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[2] *Alford v. DCH Foundation Group Long-Term Disability Plan*, 311 F.3d 955, 957 (9th Cir. 2002) (holding that an administrator's decision is reviewed de novo where the claimant presents material, probative evidence tending to show that a conflict of interest caused a breach of the claims administrator's fiduciary duties, and the administrator fails to rebut the presumption by producing evidence that the conflict did not affect its decision to deny benefits).

[3] ER vol. 2 at 294.

[4] ER vol. 2 at 287-88.

[5] ER vol. 2 at 288.

[6] *Amato v. Bernard*, 618 F.2d 559, 566-68 (9th Cir. 1980).

But she didn't. Instead of appealing the decision and engaging in the "meaningful dialogue between ERISA plan administrators and their beneficiaries" that she now claims to care so much about,[7] Plaintiff filed this lawsuit. But because the lawsuit was premature, the parties agreed to complete the administrative review process before Plaintiff's claims were adjudicated by the district court.[8] Therefore, Plaintiff conducted discovery and submitted additional evidence for Alta to consider that it did not have at the time of the initial decision. Alta then reviewed the supplemented administrative record and decided whether to accept or deny the claim.[9]

In June 2002 Alta issued its final decision, which denied Plaintiff's claim.[10] Alta's final decision stated two independent reasons for denying the claim: (1) the evidence in the administrative record established that a waiver of premium application was not submitted within 12 months from the onset of Dr. Abatie's

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[7] *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461 (9th Cir. 1997).

[8] ER vol. 1 at 27: "After filing her initial complaint, the parties engaged in discovery and supplemented the administrative record. Pursuant to stipulation, ALTA performed a further review of the claim."

[9] Tr. of 10/29/01 at 10-11; Tr. of 03/18/02 at 6-8; ER vol. 1 at 3, ¶ 11; ER vol. 1 at 10.

[10] ER vol. 1 at 212-222.

disability;[11] and (2) the evidence in the administrative record showed that Dr. Abatie did not remain totally and continuously disabled until his death.[12]

The litigation moved forward only after Alta issued its final decision and the administrative review process was completed. After Alta issued its final decision, Plaintiff filed an amended complaint.[13] That was the first time Plaintiff alleged any claims based on ERISA. Then the parties submitted the dispute to the district court for a decision.[14] In the trial to the district court Alta relied on the same grounds for denying Plaintiff's claim—no more and no less—that it had articulated in its final decision in the administrative review process.

This chronology demonstrates that Plaintiff's argument is factually inaccurate. Contrary to Plaintiff's assertion, Alta did not, in litigation, raise a new grounds for denying the claim that had not been articulated during the administrative review process. Instead, Alta took precisely the same positions that it had articulated in its decision concluding the administrative review process.

It is true that Alta's final decision included a reason for denying the claim that was not presented in Alta's initial decision. And it is also true that Alta's final

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[11] ER vol. 1 at 218.

[12] ER vol. 1 at 220-21.

[13] ER vol. 1 at 1-5.

decision, issued at the end of the administrative review process, came after litigation had begun. But that's true only because Plaintiff prematurely and improperly filed suit before exhausting her administrative remedies.

Thus, this is not a case where, during litigation, the claims administrator bolstered its denial by advancing an argument that was not articulated in the administrative review process. Here, every reason that Alta relied on in litigation was presented during the administrative review process. The only reason the administrative review process concluded after litigation had begun was because Plaintiff precipitately filed a lawsuit instead of pursuing her administrative review options.

Plaintiff relies on several cases from other circuits holding that a claims administrator may not assert in litigation a basis for denial that was not articulated during the administrative review process. But those cases are distinguishable for the simple reason that they involve grounds for denial asserted for the first time *after* the administrative review process had ended. For example, in *Glista v. Unum Life Ins. Co. of America*,[15] during the administrative review process the administrator relied on a single grounds for denying a claim for disability benefits. But during litigation the administrator relied on an additional grounds that was

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[14] ER vol. 1 at 145.

never mentioned during the administrative review process. Holding that it was improper to defend a lawsuit on a basis not articulated during the administrative review process, the court refused to consider the newly-raised argument.[16] Thus, *Glista* is distinguishable from the present case because *Glista* involved a basis for denial asserted in litigation that was never mentioned during the administrative review process.

Similarly, *Marolt v. Alliant Techsystems, Inc.*[17] involved a grounds for denial raised for the first time in litigation after the administrative review process was finished. And *Halpin v. W.W. Grainger, Inc.*[18] also involved a grounds for denial raised for the first time in litigation after the administrative review process had ended. Another case relied on by Plaintiff, *Abram v. Cargill, Inc.*,[19] involved an administrator's obligation to delay its decision until after furnishing a claimant with medical records that the claimant had not seen—a scenario not present here.

Thus, Plaintiff relies on cases that are factually distinguishable because they involve grounds for denial asserted for the first time only after the administrative

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[15] *Glista v. Unum Life Ins. Co. of America*, 378 F.3d 113 (1st Cir. 2004).

[16] *Id.* at 131-32.

[17] *Marolt v. Alliant Techsystems, Inc.*, 146 F.3d 617 (8th Cir. 1998).

[18] *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685 (7th Cir. 1992).

[19] *Abram v. Cargill, Inc.*, 395 F.3d 882 (8th Cir. 2005).

review process was completed. None of those cases involved the scenario present here, where the plaintiff's premature lawsuit caused the administrative review process to finish after litigation was commenced. Furthermore, the cases cited by Plaintiff involved administrators who raised in litigation grounds for denial that had never been expressed during the administrative review process. Here, every argument that Alta asserted in litigation was expressed in the administrative review process.

In summary, in litigation before the district court, Alta relied on only the grounds for denial that it expressed during the administrative review process, and Alta did not assert in litigation any basis for denial that it had not relied on in the administrative review process. Therefore, there is no merit to Plaintiff's argument. And because Alta did nothing improper, this court correctly held that Plaintiff failed to present material, probative evidence that Alta's decision was affected by a conflict of interest.

2. Even if Alta had committed a procedural violation, a less deferential standard of review would not be justified.

Even if Plaintiff were correct and, in litigation, Alta had relied on a grounds for denying the claim that it had not raised in the administrative review process, Plaintiff would still lose.

Plaintiff's grievance pertains to an alleged procedural defect, rather than a substantive error. Thus, we consider what this court has said about the consequences of a procedural misstep. In *Gatti v. Reliance Standard Life Ins. Co.*[20] the court addressed for the first time "whether procedural violations of ERISA regulations justify a non-deferential standard of review."[21] The court answered that question by holding that "procedural violations of ERISA do not alter the standard of review unless those violations are so flagrant as to alter the substantive relationship between the employer and employee, thereby causing the beneficiary substantive harm."[22] We now apply that standard to this case.

First, of course, Alta committed no procedural violation at all because, as the panel ably explained, a final decision may include grounds not articulated at earlier stages of the administrative review process. But even if there were a procedural violation here, it did not cause any substantive harm.

Gatti held that a procedural violation justifies shifting the standard of review only if the violation is flagrant and causes substantive harm. But Plaintiff neither discusses *Gatti* nor makes any effort to show how Alta's supposed procedural

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[20] *Gatti v. Reliance Standard Life Ins. Co.*, 415 F.3d 978 (9th Cir. 2005).

[21] *Id.* at 984.

[22] *Id.* at 985.

violation substantively harmed her. Instead, Plaintiff essentially argues for a per se rule that *any* procedural violation results in de novo review. But this court rejected such a rule in *Gatti*. Furthermore, in evaluating whether the alleged procedural violation caused any substantive harm, it's interesting to look at what Plaintiff said at the time that Alta issued the final decision.

After Alta issued its final decision, Plaintiff's attorney wrote an eight-page letter to Alta expressing each of Plaintiff's objections to the decision.[23] That letter argued (among other things) that Alta's decision was wrong because the evidence established that Dr. Abatie was continuously and totally disabled until death. Thus, Plaintiff disagreed with Alta's decision and argued that the evidence pointed in a different direction concerning whether Dr. Abatie was continuously and totally disabled until death. But the letter from Plaintiff's attorney did not argue that there was anything either unfair or procedurally improper about denying Plaintiff's claim on the grounds that Dr. Abatie did not remain totally and continuously disabled until death. And the letter from Plaintiff's attorney did not ask for the opportunity to submit additional information concerning that issue, or otherwise express that Plaintiff was surprised by Alta's decision. Plaintiff's failure to raise those arguments at the time she received Alta's decision demonstrates that Plaintiff did not perceive any substantive harm from Alta's alleged procedural violation. In

fact, she perceived no procedural violation at all because she knew that to prevail on her claim, she needed to establish that Dr. Abatie had been totally and continuously disabled until death, and she submitted to Alta medical records that she believed supported such a finding. Plaintiff's lawyer did not argue that Plaintiff was caught by surprise by Alta's decision because she wasn't.

Furthermore, the cases Plaintiff relies on do not support her argument that Alta's alleged procedural error warrants a less deferential standard of review. In *Glista*,[24] *Marolt*,[25] and *Halpin*[26]--all cases where the claims administrator improperly raised a new grounds for denial after the administrative review process was complete—the appellate court simply refused to consider the newly-raised argument; in none of those cases did the court apply a less-deferential standard of review to the administrator's decision. Therefore, even if Plaintiff's argument were factually correct, the proper remedy would be for this court to simply ignore the newly-raised grounds, and look at solely the basis for denial that Plaintiff concedes was properly articulated in the administrative review process. And if the court did that, Alta would still win because, as this court held, there were two

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[23] ER vol. 1 223-30.

[24] 378 F.3d at 131-32.

[25] 146 F.3d at 620.

[26] 962 F.2d at 696.

independent reasons for denying Plaintiff's claim. Therefore, even if one is ignored, the other still justifies affirming Alta's decision.

Finally, Plaintiff argues that the panel's decision conflicts with *Jebian v. Hewlett-Packard Co.*[27] *Jebian* involved the consequences of an administrator's failure to decide a claim before the claim was deemed denied because of the passage of time pursuant to a plan provision providing that any claim not decided within a specified time was "deemed denied." In holding that a de novo standard of review applied in those circumstances (even though the plan conferred discretion on the administrator), the court noted the possibility that a different rule would allow administrators to justify denials based on grounds never articulated during the administrative review process.[28]

As explained previously, Alta did not raise in litigation any basis for denial that was not articulated in the administrative review process, so the court's concern in *Jebian* is absent here. Furthermore, *Jebian* expressly declined to address the consequences of a procedural violation—a question the court answered in *Gatti*.[29] Therefore, Plaintiff's characterization of *Jebian* is just wrong.

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[27] *Jebian v. Hewlett-Packard Co.*, 349 F.3d 1098 (9th Cir. 2003).

[28] *Id.* at 1104.

[29] *Id.* at 1105 (declining to address the "more general issue" of the consequences of a procedural violation).

In summary, Alta did nothing improper. In particular, it did not raise in litigation a basis for denying Plaintiff's claim that was not raised in the administrative review process. But even if Alta had done that, it would not justify applying a de novo standard of review because Plaintiff has not identified any substantive harm caused by Alta's supposed procedural violation. And other courts, faced with a newly-raised argument, have simply ignored the newly-raised grounds and decided the case based on the properly-preserved bases for denying the claim. For all of these reasons, Plaintiff's first argument in support of her petition for review is without merit.

B. The panel did not hold that Alta did not have to consider the Peter deposition testimony; instead, the panel held that Alta *did* consider the testimony, but that Alta was not required to specifically discuss the testimony in its final decision.

Plaintiff's other argument concerns the role of Melissa Peter's deposition testimony. Plaintiff argues that the panel erred by holding that Alta was not required to consider Peter's testimony. The problem with this argument is that the court rendered no such holding.

Alta's 11-page final decision did not expressly discuss Peter's deposition testimony (although it did discuss exhibits from her deposition). Based on that fact alone, Plaintiff's appeal briefs argued that Alta had improperly failed to even consider Peter's deposition testimony. Significantly, Plaintiff's appeal briefs made

no argument about whether Alta was required to *discuss* the Peter deposition in its decision.

The panel's decision contained two holdings. First, it rejected Plaintiff's argument that Alta must not have considered the Peter deposition since it was not mentioned in Alta's final decision. Instead, the panel held that the administrative record established that Alta considered the Peter deposition because Alta's final decision said it was based on the administrative record "as a whole," and the administrative record "as a whole" necessarily included the Peter deposition.[30]

The panel then addressed whether Alta was required to *discuss* (as opposed to *consider*) the Peter deposition. And the panel held that the Peter deposition was not the type of evidence that a claims administrator is required to discuss in its claims decision.[31]

Now, in her petition for rehearing, Plaintiff argues that the panel erred by holding that Alta was entitled to ignore the Peter deposition. But, as the foregoing discussion demonstrates, Alta has never made that argument, and the panel didn't state such a holding. Alta has never argued that, once the deposition was submitted, it was not required to consider the Peter deposition. Alta never needed

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[30] *Abatie*, 421 F.3d at 1063.

[31] *Id.* at 1064-65.

to make that argument because Alta *did* consider the deposition testimony. Thus, Alta did not argue, and the panel did not hold, that Alta could (and did) ignore the Peter deposition. The panel had no occasion to even address that issue because it held that Alta *did* consider the testimony.

The panel also held that Alta was not required to expressly discuss the Peter deposition in its final decision. The panel was not required to address that issue because it was not raised by either party: Plaintiff's briefs did not argue that Alta was required to discuss the Peter deposition, and, consequently, Alta's appeal brief didn't address that issue, either.

In addressing that question, the panel identified several independent reasons why Alta was not required to expressly discuss the Peter deposition. One reason it identified was that Alta was not required to seek out that kind of evidence in the first place. The court explained that, because the plan said the waiver of premium application was required to be in writing, Alta would have been entitled to decide the claim based on only whatever written evidence existed concerning the submission of the waiver of premium application, and Alta was not required to interview or depose former clinic employees such as Peter. The court further reasoned that since the deposition testimony was not the type of evidence that, in this case, Alta was required to obtain in order to decide the claim, Alta had no obligation to discuss the evidence. Thus, the panel did not hold that Alta had no

obligation to consider the deposition testimony once it was submitted to Alta. As explained above, the panel had no reason to address that issue because Alta *did* consider the Peter testimony. Instead, the panel's point was that Alta's final decision was not required to discuss the deposition testimony since it would have been permissible for Alta to decide the claim without seeking out that type of evidence.

Furthermore, Alta wins even if Plaintiff's argument is correct. As noted above, the panel held that Alta *did* consider the Peter deposition testimony—a holding not challenged by Plaintiff's petition for rehearing. Therefore, even if the panel had also held that Alta was not required to consider the deposition testimony, any such holding would have been dicta because Alta *did* consider the testimony. Consequently, even if the court agrees with Plaintiff's argument, the case's outcome remains the same.

CONCLUSION

The petition for rehearing should be denied.

DATED this 6th day of October, 2005.

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CERTIFICATE OF COMPLIANCE
PURSUANT TO RED. R. APP. P. 32(A)(7)(c)
AND CIRCUIT RULE 32-1

I certify that the attached brief is proportionately spaced, has a typeface of 14 points or more and contains 4, 102 words.

DATED: October 6, 2005.

/s/ R. DANIEL LINDAHL

R. Daniel Lindahl

CERTIFICATE OF SERVICE

I hereby certify that on October 6, 2005, two true and correct copies of the foregoing **ANSWER TO PETITION FOR REHEARING** were served on each of the following by depositing the same in the United States mail in Portland, Oregon, enclosed in a sealed envelope with postage thereon fully prepaid and addressed as follows:

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